46.02: continued

Alcoholism Recovery Home. The program of services defined as a 'Halfway House' in the Massachusetts Department of Public Health's Rules and Regulations for Halfway Houses for Alcoholics. (105 CMR 165.000)

Approved Program Rate. The rate per service unit approved by the Division and filed with the Secretary of the Commonwealth.

Case Consultation. Consultation with another agency or person when the provider has accepted a patient for treatment and continues to assume primary responsibility for the patient's treatment, while the other agency continues to provide ancillary services.

Case Management. Services, as specified by the Diviison of Medical Assistance, that coordinate the substance abuse treatment of pregnant women with the other medical and community services which are critical to the needs of the woman and her pregnancy. Case Management is billable only for women enrolled in the Intensive Outpatient Program. Service is limited to one hour per week per enrollee, provided in no less than 15 minute increments.

Clients. Recipients of service units within a program.

Client Resources. Revenue received in cash or in kind from publicly assisted clients to defray all or a portion of the cost of program services. Client resources may include payments made by publicly assisted clients to defray the room and board expense of residential services, clients' food stamps, or payments made by clients according to ability to pay or sliding fee scale.

Cost Report. The document used to report costs and other financial and statistical data. The Uniform Financial Statements and Independent Auditor's Report (UFR) are used when required.

Couple Counseling. Therapeutic counseling provided to a couple whose primary complaint or concern is disruption of their relationship and/or family, due to Substance Abuse.

Day Treatment. A highly structured substance abuse treatment day program that meets the service criteria set forth by the Department of Public Health and the Division of Medical Assistance. A Day Treatment Program operates at least four hours per day, five to six days per week.

Division. The Division of Health Care Finance and Policy, appointed under M.G.L. c. 118G.

Driver Alcohol Education. The program of services, provided through licensed substance abuse counseling programs, legislated by M.G.L. c. 90, § 24D to first offender drunk drivers adjudicated in Massachusetts courts.

Educational/Motivational Session. A meeting between staff of a Driver Alcohol Education Program and not more than 12 clients. Clients are required to participate in 32 hours of this interactive group programming either in 16 two-hour groups or 21 90-minute groups.

Eligible Provider. Any individual, group, partnership, trust, corporation or other legal entity which offers services for purchase by a governmental unit and that meets the conditions of purchase or licensure which have been or may be adopted by a purchasing governmental unit.

Enhanced Acute Treatment Services. A program to detoxify pregnant women from alcohol and/or drugs that involves special medical protocols to address the needs of pregnancy and that includes other medical and support components to ensure quality of both substance abuse treatment and obstetrical care.

46.02: continued

Established Charge. The lowest fee that is charged by the eligible provider to the general public or any third party payor, other than a governmental unit, for the provision of one program service unit. Fees which are based upon the client's ability to pay, as in the case of a sliding fee scale, and fees that are subject to Division review and approval shall not be deemed to be established charges.

Family Counseling. The therapeutic counseling of more than one member of a family at the same time in the same session, where the primary complaint or concern is disruption of the family due to Substance Abuse.

Group Counseling. Therapeutic counseling to an unrelated group of people having a common problem or concern which is associated with Substance Abuse. Groups are limited to 12 clients.

Governmental Unit. The Commonwealth of Massachusetts and any Board, Commission, Department, Division, or Agency of the Commonwealth of Massachusetts or political subdivision thereof.

Individual Counseling. A therapeutic meeting between an individual whose primary complaint or concern is Substance Abuse, and the staff of an eligible provider.

Individual Assessment Session. A meeting between staff of a Driver/Alcohol Education Program and an individual client to explore the client's drinking habits and to place the client in the appropriate educational track in the group programs. Each client must participate in two hours of assessment.

Methadone Medical Services Visit. A methadone medical services visit includes medical assessment, medical case management, and dispensing of medication to opiate addicted individuals who require support of methadone chemotherapy, as noted in the Department of Public Health's standard RFP program description.

Operating Agency. An individual, group partnership, corporation, trust or other legal entity that operates a program.

Publicly Assisted Client. A person who receives program services for which a governmental unit is liable, in whole or in part, under a statutory program of financial assistance.

Purchasing Governmental Unit. A governmental unit that has purchased or is purchasing service units from an eligible provider.

Reimbursable Operating Costs. Those costs reasonably incurred or expected to be incurred by a program in the provision of care except those costs delineated in accordance with 114.3 CMR 46.04.

Related Party. A person or organization that is associated or affiliated with, has control of, or is controlled by the operating agency or any director, stockholder, partner, or administrator of the operating agency by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended, provided, however, that 10% shall be the operative factor as set out in sections 267(b)(2) and (3) and provided further that the definition of "family members" found in section 267(c)(4) of said code shall include for the purpose of 114.3 CMR 46.00:

(a) husband and wife,
(b) natural parent, child, and sibling,
(c) adopted child and adoptive parent,
(d) stepparent and stepchild,
(e) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law, and
(f) grandparent and grandchild.

46.02: continued

Reporting Year. The operating agency's fiscal year for which costs incurred are reported to the Operational Services Division on the Uniform Financial Statements and Independent Auditor's Report (UFR), normally July 1st to June 30th.

Residential Drug-Free Program. The program of services defined in the Massachusetts Department of Public Health Regulation 105 CMR 750.000 Licensure and Approval of Drug Treatment Programs.

Substance Abuse Outpatient Counseling. The services defined in the Massachusetts Department of Public Health Regulation 105 CMR 162.00. Licensure of Substance Abuse Outpatient Services.

46.03: Filing and Reporting Requirements

(1) Reporting for Annual Review. Unless exempted herein, each Operating Agency shall on or before the 15th day of the fifth month after the end of its fiscal year, submit to the Division:
(a) a copy of its Uniform Financial Statement and Independent Auditor's report completed in accordance with the filing requirements of the Operational Services Division, Department of Administration and Finance.
(b) Supplemental program questionnaire, if requested by the Division.

(2) Penalties.
(a) An Operating Agency's Approved Rate shall be reduced by 25% of the Approved Rate for the number of late days. Late days shall be defined as the total number of days between the Operating Agency's due date for filing a completed Cost Report package as defined in 114.3 CMR 46.03(1) and the date the Operating Agency's completed Division Cost Report package as defined in 114.3 CMR 46.03(1) is received by the Division.
(b) Additional Information Requested by the Division. Each Operating Agency shall file such additional information as the Division may from time to time require no later than 21 days after the date of mailing of that written request. If the Division's request for the missing information and/or documentation is not fully satisfied through the submission of written explanation(s) and/or documentation within 21 days of the mailing of that request, all costs relative to that request shall be excluded from rate development.

(3) General Provisions.
(a) Accurate Data. All reports, schedules, additional information, books, and records that are filed or made available to the Division shall be certified under pains and penalties of perjury as true, correct and accurate by the Executive Director or Chief Financial Officer of the Operating Agency.
(b) Examination of Records. Each Operating Agency shall make available all records relating to its operation and all records relating to a realty service or related party or holding company or any entity in which there may be a common ownership or interrelated directorate upon request of the Division for examination.
(c) Field Audits. The Division may from time to time conduct a field audit. The Division shall make reasonable attempts to schedule an audit at the mutual convenience of both parties.

46.04: Rate Provisions

(1) Services included in the Rate. The approved rate shall include payment for all care and services that are or have been customarily part of the program of services of an eligible provider, subject only to the terms of the purchase agreement between the eligible provider and the purchasing governmental unit(s).

46.04 continued

(2) Reimbursement as Full Payment. Each eligible provider shall, as a condition of acceptance of payment made by one or more purchasing governmental units for services rendered, accept the approved program rate as full payment and discharge of all obligations for the services rendered, subject only to appellate rights as set forth in M.G.L. c. 118G. There shall be no duplication or supplementation of payment from sources other than those expressly recognized or anticipated in the computation of the rate. Any client resources or third party payments received on behalf of a publicly assisted client shall reduce, by that amount, the amount of the purchasing governmental unit's obligation for services rendered to the publicly assisted client.

(3) Payment Limitations. Except as provided in 114.3 CMR 46.04(2), no purchasing governmental unit may pay less than or more than the approved program rate.

(4) Approved Program Rates. The rate of payment for authorized services shall be the lower of the established charge or rate listed below:

(a) Services paid by all public purchasers *except* Medicaid:

Service	Rate
1. Acute Inpatient Treatment Services	
Level IIIA	$ 140.00 per day
Level IIIB	$ 100.00 per day
Level IIIC	$ 70.00 per day
2. Enhanced Acute Treatment Services	$49.95 per day *plus* proper Acute Treatment services base rate from 114.3 CMR 46.04(4)(a)1.
3. Day Treatment	$ 55.00 per day
4. Alcoholism Recovery Home;	$ 53.25 per day
5. Driver Alcohol Education;	
Individual Assessment Session	$ 51.08 per hour
Educational/Motivational Session	$ 19.88 per 1½ hr.
6. Substance Abuse Outpatient Counseling;	
Individual Counseling	$ 51.08 per hour
Couple/Family Counseling	$ 61.32 per hour
Group Counseling	$ 19.88 per 1½ hr.
Case Consultation and Methadone Counseling:	$ 51.08 per hour
7. Methadone Medical Services visit	$ 9.61 per visit
8. Residential Drug-Free;	$ 53.25 per day

(b) Services paid by Medicaid:

Service	Rate
1. Acute Inpatient Treatment Services	
Level IIIA	$ 140.00 per day
Level IIIB	$ 100.00 per day
Level IIIC	$ 70.00 per day
2. Enhanced Acute Treatment Services	$49.95 per day *plus* proper Acute Treatment services base rate from 114.3 CMR 46.04(4)(a)1.

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46.04: continued

Service	Rate
3. Day Treatment	$55.00 per day
4. Case Management	$8.00 per 15 minute session
5. Substance Abuse	
Outpatient Counseling:	
Individual Counseling	
Couple/Family Counseling	$ 50.68 per hour
Group Counseling	$ 60.84 per hour
Case Consultation and Methadone	$ 19.72 per 1½ hr.
Counseling	$ 50.68 per hour.
6. Methadone Medical Services Visit	$ 9.61 per visit

46.05: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.3 CMR 46.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.3 CMR 46.00 if necessary for informed consideration of program rate requests.

46.06: Severability of the Provisions of 114.3 CMR 46.00

The provisions of 114.3 CMR 46.00 are severable, and, if any provision of 114.3 CMR 46.00 or application of such provision to any eligible provider or fiscal intermediary in any circumstance shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.3 CMR 46.00 or application of such provisions to eligible providers or fiscal intermediaries in circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 46.00: M.G.L. c. 118G.

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TN 97-14
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 9: G.L. c.111 § §24F and 24G

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TN 97-14
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 7: 114.6 CMR 7.00

114.6 CMR 7.00: ADMINISTRATION OF ACUTE HOSPITAL UNCOMPENSATED CARE POOL AND CRITERIA FOR CREDIT AND COLLECTION POLICIES UNDER M.G.L. c. 118G

Section

7.01: General Provisions

(1) Scope and Purpose.

(a) 114.6 CMR 7.00 implements the provisions of M.G.L. c. 118G, regarding the acute hospital uncompensated care pool.

(b) The purpose of 114.6 CMR 7.00 is to specify:

1. The rules which will govern payment by hospitals to the pool and payment by the pool to hospitals.

2. The procedures that acute care hospitals must follow regarding the acquisition and verification of patients' financial resource information for determination of patients' ability to pay for hospital care provided and/or to be provided.

3. The criteria that acute care hospitals must meet regarding notification of the availability of free care and public assistance programs to patients.

4. The criteria that acute care hospitals' credit and collection policies must meet regarding bad debt and free care accounts. This shall include, the standards for reasonable collection effort of bad debt accounts; the standards for determining free care accounts; and the standards for documenting bad debt and free care accounts.

5. The administration of the Uncompensated Care Pool surcharge assessed on payments to hospitals and ambulatory surgical centers.

(2) Authority: 114.6 CMR 7.00 is adopted pursuant to M.G.L. c. 118G.

(3) Organization: 114.6 CMR 7.00 is divided into sections. Each section may be further divided into subsections designated by arabic numerals enclosed in parentheses. A subsection may be segregated into divisions, designated by letters enclosed in parentheses. A division may be further segregated into subdivisions designated by arabic numerals followed by a period.

7.02: Definitions

Actual Costs. All direct and indirect costs incurred by a hospital or a community health center in providing medically necessary care and treatment to its patients, in accordance with generally accepted accounting principles.

Acute Hospital. Any hospital licensed under M.G.L. c. 111, § 51 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Allowable Free Care Costs. The total free care charges of a hospital multiplied by its cost-to-charge ratio.

7.02: continued

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Finance Administration for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC § 1395k(a)(2)(F)(I). These services include facility services only and do not include physician fees.

Bad Debt. An account receivable based on services furnished to any patient which:

(a) is regarded as uncollectible, following reasonable collection efforts. pursuant to the hospital's credit and collection policies and procedures;

(b) is charged as a credit loss pursuant to the hospital's credit and collection policies and procedures;

(c) is not the obligation of any governmental unit of the federal or state government or agency thereof; and

(d) is not free care.

Charge. The uniform price for each specific service within a revenue center of an acute hospital established in accordance with M.G.L. c. 6B, § 7.

Children's Medical Security Plan. A program of primary and preventive pediatric health care services for certain children, from birth through age 18, administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24G.

Collection Action. Any activity by which a hospital or its designated agent requests payment for services from a patient or a patient's guarantor. A collection action of a hospital shall include those activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commission. The Rate Setting Commission established under M.G.L. c. 6A, § 32., now the Division of Health Care Finance and Policy.

Compliance Liability. Pursuant to St. 1991, c. 495, § 56, hospitals which over generated approved revenues under St. 1988, c. 23 are required to pay a portion of such excess revenue into the Uncompensated Care Trust Fund established under M.G.L. c. 118G,. For the purpose of 114.6 CMR 7.00, the payment of such excess revenue shall be referred to as a hospital's "Compliance Liability." The Commission is responsible for determining each hospital's Compliance Liability which covers hospital fiscal years 1988 through 1991.

Cost-to-Charge Ratio. A calculation to be used by the Division of Health Care Finance and Policy in determining the uncompensated care pool's liability to each hospital in accordance with M.G.L. c. 118G.

Credit and Collection Policy. The hospital's policy, as expressed in a statement of general principles approved by its governing board, guiding the management of the hospital's billing and collection of accounts receivable, and the hospital's procedures, as expressed in an operating plan to implement such policy, with respect to:

(a) the effort the hospital makes to collect payment for services;

(b) the criteria the hospital uses to assign uncollectibles to bad debt account; and

(c) the criteria the hospital uses for the provision of free care. The credit and collection policy shall include, as a minimum, the methods the hospital uses, the practices it follows and the forms or schedules it adopts in order to comply with the Division's criteria and standards for credit and collection policy as set forth in 114.6 CMR 7.00.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

7.03: continued

In addition, each acute care hospital shall file in the UB-92 format, information regarding its uncollected costs for emergency care to uninsured patients. Each acute care hospital shall make a good faith effort to report the utilization information on the number of inpatient admissions and outpatient visits by the following categories:

1. date of birth;
2. family income by the following categories:
   a. equal to or less than 200% of the Federal Poverty Income Guidelines;
   b. income between 200% and 400% of the Federal Poverty Income Guidelines; or
   c. income above 400% of the Federal Poverty Income Guidelines.
3. primary diagnosis and up to six co-existing secondary diagnoses by ICD-9 for inpatient admissions and for outpatient visits;
4. charges for services rendered;
5. billing number;
6. medical record number (optional); and
7. date of admission and/or date of discharge if inpatient and date of service if outpatient.

Each acute hospital shall, upon request, provide the Division or its agent with access to patient account records and related reports.

(e) Each acute hospital shall file or make available information which is required by 114.6 CMR 7.03 or which the Division deems reasonably necessary for implementation of 114.6 CMR 7.00 in accordance with time limits set forth in 114.6 CMR 7.03, or within 15 days from the date of request from the Division, unless a different time is specified in the request. The Division may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budgets, information, books and records. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(2) Enforcement of Reporting Requirements. If a hospital fails to meet the reporting requirements of 114.6 CMR 7.03(1), the Division may determine that the hospital does not incur any free care expenses for the period for which it fails to meet the reporting requirements. If the Division makes such a determination it will adjust the hospital's liability to or from the uncompensated care pool as calculated pursuant to 114.6 CMR 7.04 to reflect this determination.

7.04: Payments To and From the Uncompensated Care Pool

Each acute hospital shall make payments to or receive payments from the uncompensated care pool in accordance with 114.6 CMR 7.04.

(1) Payments to the Division or its agent shall be made in accordance with instructions from the Division.

→(2) Penalties (Effective May 1, 1997). If any part of the hospital's liability amount is not paid 45 days after the due date, the Division will assess a 1.5% penalty on the outstanding balance. The penalty will be calculated from the due date of the invoice. For each month a hospital remains delinquent, an additional 1.5% penalty will be assessed against the outstanding balance, including prior penalties.

(a) Partial payments received from delinquent hospitals will be credited first to the current outstanding liability, and second to the amount of the penalties.

(b) The Division may waive or reduce a hospital's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the hospital's payment history, the hospital's financial situation, and the hospital's relative share of the payments to the uncompensated care pool.

7.04: continued

(3) Division of Medical Assistance (DMA) payment offset (Effective August 25, 1997). If a hospital does not meet its obligation to make scheduled payments to the uncompensated care pool, and has maintained an outstanding obligation to the uncompensated care pool for more than 45 days, the Division may notify DMA to offset payments on the hospital's Title XIX claims in the amount the hospital's outstanding obligation to the uncompensated care pool, including penalties, plus a 5% surcharge on the outstanding amount. Payments offset in accordance with this provision will be credited to the hospital's outstanding liability to the uncompensated care pool. The late fee amount will also be deposited into the uncompensated care pool.

(a) The Division will notify the hospital in writing of the dollar amount to be offset from the hospital's DMA claims. Such notification will be sent to the hospital via certified mail at least ten days prior to notifying DMA. Any dispute by the hospital regarding the payment offset should be made to the Division of Health Care Finance and Policy within this ten day notification period. No dispute by the hospital regarding the payment offset is appealable to DMA.

(b) The Division will notify DMA in writing of the dollar amount to be offset from the hospital's DMA claims.

(c) Hospitals to which payment is offset will serve all Title XIX recipients in accordance with the contract then in effect with the Division of Medical Assistance, or, in the case of a non-contracting hospital or disproportionate share hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to M.G.L. c. 118G.

(4) Payment schedules (Effective May 1, 1997). Where a financial hardship is determined, the Division may, at its discretion, establish a payment schedule for a given hospital. The payment schedule may include an interest charge.

(a) The interest rate used for the payment schedule will not exceed the prime rate plus 2%. The prime rate used will be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.

(b) A hospital may make a full or partial payment of its outstanding liability at any time without penalty.

(c) If a hospital fails to meet the obligations of the payment schedule, the Division may assess penalties pursuant to 114.6 CMR 7.04 (2) and (3).

(5) Revenue available for payments to hospitals for free care (Effective May 1, 1997).

(a) The revenue available shall consist of revenues produced by hospital assessments under 114.6 CMR 7.04, state appropriations of federal financial participation funds, any other appropriations, and any supplemental funding, less reserves, payments to community health centers under 114.6 CMR 8.04, and uncompensated care pool expenses for activities authorized in M.G.L. c. 118G, § 18.

(b) For FY 1997, supplemental funding shall consist of $15 million transferred from Compliance Liability revenue.

(c) Supplemental funding shall be the primary source of funding for free care to community health centers. If this funding source is insufficient, then revenue provided through other sources will be made available. Any supplemental funding remaining after payments to community health centers will be made available for other purposes of the pool.

(6) Gross Payments to or from the Uncompensated Care Pool. Each hospital's payments to and from the uncompensated care pool shall be based on gross liability to and from the uncompensated care pool. The Division will determine the gross liability of a hospital to or from the uncompensated care pool as follows:

(a) The hospital shall make payments of its gross liability to the uncompensated care pool in accordance with the invoices from the Division. The Division shall make the appropriate gross payment from the uncompensated care pool to the hospital.

(b) The hospital's fiscal year gross liability to the uncompensated care pool shall be calculated as follows:

1. for the time period of October 1, 1991 to September 30, 1992, inclusive, it will be as set forth in St. 1991, c. 495, § 54;
2. for the time period beginning on October 1, 1992, it will equal the product of:
   a. the ratio of its private sector charges to all hospitals' private sector charges; and

7.04: continued

b. the private sector liability to the uncompensated care pool as determined by the general court.

(c) The uncompensated care pool's gross liability to the hospital shall be determined as follows:

1. pool's gross liability to each hospital shall be equal to the total allowable free care costs of the hospital less the pool shortfall allocation;

2. the total allowable free care costs shall be the product of the cost-to-charge ratio and the total free care charges less free care income, related bad debt recoveries and audit results. Gross free care charges shall not include any sums attributable to free care for which reimbursement is available from other sources including, but not limited to, the Medicare program, foreign health insurance coverage, and a motor vehicle liability policy irrespective of whether such reimbursement has been collected by a hospital. Unpaid Medicare charges, unpaid charges covered by either a foreign health insurance policy or through a foreign governmental health program, and unpaid charges covered by a motor vehicle liability policy shall be considered reimbursable by the pool to the extent allowed under 114.6 CMR 7.02: Free Care.

3. the pool shortfall allocation shall be the lesser of the product of the ratio of the hospital's total patient care costs to the total patient care costs of all hospitals, multiplied by the shortfall amount or the amount equal to the total allowable free care costs of the hospital.

(d) If a hospital is unable to determine the appropriate segregation of bad debt related to emergency care from the bad debt related to non emergency care for any fiscal year, then the Division shall make an appropriate estimate. If a hospital is unable to determine recoveries, the Division shall estimate the amount of recoveries of bad debt which is attributable to bad debt arising from the emergency care to uninsured patients on the basis of the ratio of the total of the bad debt recoveries to the total of the bad debt.

(7) Interim Calculation of a Hospital's Payment to or from the Uncompensated Care Pool. In order to facilitate timely payments to and from the uncompensated care pool, the Division will from time to time calculate each hospital's payment to and from the uncompensated care pool for a fiscal year by estimating its liability to and from the uncompensated care pool and crediting any payments made to and from the uncompensated care pool for the fiscal year in question. The calculation shall be made according to the following guidelines:

(a) The Division shall notify each hospital of the methodology used to calculate payments and the results of the calculation for the hospital;

(b) If a hospital has not reported data required to calculate the hospital's net payment, the Division may substitute for the required data elements relevant industry averages, prior year reports by the hospital, or other data the Division deems appropriate;

(c) The Division shall adjust payments to reflect the availability of funds, as well as any special payments made under 114.6 CMR 7.04(12).;

(d) The Division may adjust payments to reflect uncompensated care pool expenses for activities authorized in M.G.L. 118G.

(e) The Division may borrow against the penalty, late fee, and interest revenue collected pursuant to 114.6 CMR 7.04(2), 114.6 CMR 7.04(3), and 114.6 CMR 7.04(4) to cover unpaid liabilities until such time as these liabilities may be collected.

(8) Final Calculation of a Hospital's Payment to and from the Uncompensated Care Pool. The final settlement between the uncompensated care pool and a hospital for a fiscal year shall comply with the guidelines set forth in 114.6 CMR 7.04(7) and it shall be as follows:

(a) It shall take place upon completion of the relevant audit and calculations by the Division, for that fiscal year;

(b) It shall be determined using actual private sector charges, final cost-to-charge ratios, and actual free care charges, each having been adjusted for any audit findings;

(c) It shall include reconciliation of any interim payments and estimated liabilities to and from the uncompensated care pool.

(d) The Division may use the penalty, late fee, and interest revenue collected pursuant to 114.6 CMR 7.04(2), 114.6 CMR 7.04(3), and 114.6 CMR 7.04(4) to cover unpaid liabilities from the settlement year that the Division has determined to be uncollectible.

7.04: continued

(9) Special Calculation for the Settlement Between the Hospitals and the Pool for the Fiscal Year of October 1, 1991 to September 30, 1992. In order to facilitate timely settlement of payments to and from the pool and to promote fair distribution of pool funds among the participating hospitals, the Division will, for the time period of October 1, 1991 to September 30, 1992, determine the gross free care charges eligible for reimbursement before adjustment as follows:

(a) For the time period of October 1, 1991 to March 31, 1992, for those hospitals which are not able to determine the amount of bad debt arising from emergency care to the uninsured, the estimate of the amount of the free care charges eligible for reimbursement before adjustment shall be calculated pursuant to the following rules and formulas:

1. the time period of October 1, 1991 to March 31, 1992 shall be designated as "P1";
2. the time period of April 1, 1992 to September 30, 1992 shall be designated as "P2";
3. the free care charges as reported on the form UC-92 (less all income, recoveries and adjustments attributable thereto) shall be designated as "FC";
4. the free care charges as reported on the form UC-92 which are attributable to bad debt arising from emergency care to uninsured patients shall be designated as "EBD";
5. the total bad debt charges as reported on the form UC-92 shall be designated as "BD";
6. the uncompensated care for any period shall be the sum of FC for such time period and BD (less all income, recoveries and adjustments attributable thereto) for such time period and shall be designated as "UC";
7. The ratio of EBDP2 to the sum of FCP2 and BDP2 shall be multiplied by UCP1. This product will be the gross free care charges which are eligible for reimbursement.

(b) For the time period of April 1, 1992 to September 30, 1992 for all hospitals and for the time period October 1, 1991 to March 31, 1992, if such reporting is refiled, for hospitals which are able to specifically segregate bad debt arising from emergency care to the uninsured for the time period October 1, 1991 to March 31, 1992, the free care charges as reported on form UC-92 less all income, recoveries and adjustments attributable thereto, shall be the gross free care charges which are eligible for reimbursement.

(10) Reimbursement of Physicians for the Cost of Free Care. Any hospital which has the status of a disproportionate share hospital pursuant to 114.1 CMR 36.08 and which receives payments from the uncompensated care pool, and such payments are based upon a calculation of the cost-to-charge ratio which includes, provides for, or has an allowance, calculated by the Division, for the cost of free care provided by physicians at such hospital, shall use that portion of the uncompensated care pool payments which is attributable to such cost to reimburse such physicians for such free care.

(11) Updates and Final Settlements. The Division may calculate all updates and make final settlements with hospitals on a net basis. The net shall be the hospital's gross liability to the uncompensated care pool, as determined pursuant 114.6 CMR 7.04(6)(b), minus the uncompensated care pool's gross liability to the hospital, as determined pursuant to 114.6 CMR 7.04(6)(c). If the difference is positive, then that amount shall be the hospital's net liability to the uncompensated care pool; if the difference is negative, then that amount shall be the net liability of the uncompensated care pool to the hospital.

(12) Special Payment. Beginning in FY 1997, the Uncompensated Care Pool will make a one-time payment to hospitals as early in the fiscal year as is administratively feasible. The total amount of this payment to all hospitals will equal the amount of supplemental funding available, less any amount transferred pursuant to 114.6 CMR 7.04(13). This payment will be allocated in accordance with 114.6 CMR 7.04(6), using the preliminary cost to charge ratio. The Division may offset any funds distributed under this section by any amounts owed by hospitals for current or prior years' unpaid liabilities. These payments will be included in final settlements calculated pursuant to 114.6 CMR 7.04(8).

7.10 continued

(3) Income Documentation for Patients Without Resources. Should a patient report that there is no current source of family income and that no prior income information is available, a sworn, signed free care application and a brief statement describing how the patient is being supported may be considered sufficient documentation for audit. A detailed description of documentation requirements for patients without financial resources should appear in a hospital's Credit and Collection Policy. The hospital official responsible for determining eligibility under 114.6 CMR 7.10(3) must attempt to verify whether a free care applicant is currently receiving medical assistance from other governmental sources. In addition, the hospital official should inform the applicant that medical assistance through other governmental sources may be available.

(4) If a hospital fails to meet the requirements of 114.6 CMR 7.00, the Division may adjust the hospital's payments from the uncompensated care pool.

(5) The Division's audit procedures regarding free care accounts and the Division's schedule of audit adjustments regarding deficiencies in documentation shall be detailed in a separate administrative information bulletin issued pursuant to 114.6 CMR 7.12. The audit adjustments will reflect the degree of non-compliance with the Division's criteria for documentation of free care accounts.

7.11: Utilization Review

(1) In order to encourage maximum efficiency and appropriateness in the utilization of acute hospital services there shall be an utilization review for hospital admissions and continued acute hospital stays.

(2) The utilization review may be conducted by the Division or its designee.

(3) Nothing set forth in 114.6 CMR 7.11 shall be construed as affecting the calculations of payments to and from the pool as otherwise provided for in 114.6 CMR 7.04.

(4) Utilization review shall be conducted for those hospital admissions and continued acute hospital stays which are included in the calculation of the gross liability of a hospital from the uncompensated care pool. An utilization review shall not be conducted in those instances where another third party payer has conducted an utilization review.

(5) Utilization review shall be administered and conducted as set forth in the "Provider Reference Guide" which is incorporated herein by reference. All terms and conditions set forth in the "Provider Reference Guide" shall have the same force and effect as if fully set forth herein. All changes or amendments to the "Provider Reference Guide" shall be governed by the same procedural requirements as are 114.6 CMR. The effective date of 114.6 CMR 7.00 set forth in 114.6 CMR 7.01(1)(c)5. shall be construed consistently with and effectuating the dates set forth in the "Provider Reference Guide."

(6) Upon exhaustion of appeal of a review determination described in the "Provider Reference Guide" a hospital may seek an administrative review by the Division. The procedure of such administrative review by the Division shall be governed by 114.6 CMR 7.05(2) and (3). Such procedure shall be adopted, as appropriate to the unique requirements of the utilization review program.

7.12: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.6 CMR 7.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.6 CMR 7.00.

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7.13: Severability

The provisions of 114.6 CMR 7.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 7.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

7.14: Calculation of the Uncompensated Care Pool Surcharge Percentage (Effective 8/25/97)

The Division will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to acute hospitals and ambulatory surgical centers, established in M.G.L. c.118G, § 18A, as added by St. 1997, c. 47.

(1) The Division will project FY 98 annual aggregate payments subject to the surcharge as follows. The following data will be obtained for Pool FY 96, or adjusted for inflation to Pool FY 96.

(a) The Division will determine total payments received by Massachusetts acute care hospitals from private managed care, non-managed care, and self-pay payers by subtracting bad debt written off and gross payments from the Pool allocated to those payers from net patient service revenue allocated to those payers, as reported on the DHCFP-403 cost report.

(b) The Division will determine total payments received by Massachusetts ambulatory surgical centers for ambulatory surgical center services from private managed care, non-managed care, and self-pay payers from data reported by these centers to the Division.

(c) The Division will determine payments from HMOs licensed in Massachusetts to Massachusetts acute care hospitals and ambulatory surgical centers that are exempt from the surcharge from data provided by these HMOs to the Division.

(d) The Division will estimate the amount of payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies based on data provided by the Auto Insurers Bureau.

(e) The Division will estimate the amount of surcharge payments that will be below the threshold for collection based on sample data provided by hospitals.

(f) The Division will make an allowance for uncollectable amounts.

(g) The Division will add the amounts determined in 114.6 CMR 7.14(1)(a) and (b), and then subtract the amounts determined in 114.6 CMR 7.14(1)(c), (d), (e), and (f). The Division will then adjust this total amount of FY 96 payments subject to the surcharge to reflect price changes between FY 96 and FY 98. The Division will use a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI) to reflect conditions in the Massachusetts economy. Specifically, the labor-related component of the HCFA market basket will be replaced by the CPI. This adjusted amount will be the Division's projected FY 98 annual aggregate payments subject to the surcharge.

(2) The Division will calculate the surcharge percentage effective October 1, 1997 by dividing $75,000,000 by seven-twelfths of the projected FY 98 annual aggregate payments subject to the surcharge determined pursuant to 114.6 CMR 7.14(1), in order to ensure that the amount loaned to the Pool will be fully repaid to the General Fund by June 30, 1998.

(3) If the Division projects that the surcharge percentage established in 114.6 CMR 7.14(2) will produce less than $90,000,000 or more than $100,000,000 by September 30, 1998, or that an adjustment is necessary in order to fully repay the General Fund by June 30, 1998 then the division may redetermine the surcharge percentage as of May 1, 1998 and as of July 1, 1998. The Division will calculate the surcharge percentage effective May 1, 1998 by dividing $75,000,000 by seven-twelfths of the projected FY 98 annual aggregate payments subject to the surcharge. The Division will calculate the surcharge percentage effective July 1, 1998 by dividing $100,000,000 by projected FY 98 annual aggregate payments subject to the surcharge. The Division will project annual aggregate payments based on historical data, with any adjustments the Divisions deems necessary.

REGULATORY AUTHORITY

114.6 CMR 7.00: M.G.L. c. 118G.

TN 97-14
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 8: 105 CMR 160.00
114.3 CMR 46.00

105 CMR 160.000: ACUTE CARE INPATIENT SUBSTANCE ABUSE DETOXIFICATION TREATMENT SERVICES

Section

Section: continued

160.001: Purpose

105 CMR 160.000 sets forth standards for the maintenance and operation of acute care inpatient substance abuse detoxification treatment services.

160.002: Authority

105 CMR 160.000 is adopted under the authority of M.G.L. c. 111B, § 6 and c. 111E, § 7.